Disenrollment of Health Care Coverage Request
Group Senior Gold and Group MedicareBlue Rx

Please disenroll me from my *Group Senior Gold* and *Group MedicareBlue Rx* insurance coverage effective_____.
(Date)
Reason for disenrollment is: _____

Member Information (*Please print your name and address below*):

Group Name: St. Louis County
Name: _____
Gender: (please check one) □ Male □ Female
Address:_____
City: _____State: _____ Zip:_____
Home Phone: _____ Date of Birth:_____
Medicare Claim #: _____

Group Senior Gold Member Identification Number _____
Group MedicareBlue Rx Member Identification Number _____

Member Identification Number is listed on your member identification card.

*** Requested disenrollment date:** _____
Member Signature: _____ **Date:** _____

***** Please note the disenrollment date must reflect the first of a calendar month. Your disenrollment date may not be dated any sooner than the first of the month following the date of your signed request.

By completing this disenrollment request, I agree to the following:
Group MedicareBlue Rx will notify me of my disenrollment date after they receive this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at *Group MedicareBlue Rx* network pharmacies in order to receive my prescription benefit. I understand that there are limited times in which I will be able to join other Medicare Advantage or Medicare prescription drug plans, unless I qualify for special circumstances.

I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I do not enroll in another Medicare Prescription Drug Plan or a Medicare Advantage with a Prescription Drug Plan at this time, or have other coverage as good as Medicare, I may have to pay a penalty for this coverage in the future.

Return Form to: St. Louis County Auditor – Retiree Accounting, 100 N 5th Ave West, Room 201, Duluth, MN 55802